


SANTA CRUZ COUNTY
Behavioral Health Services
POLICY AND PROCEDURE MANUAL

Subject: Behavioral Health Network Adequacy	Policy Number: 2107
Date Effective: 3/15/2021	Pages: 8
Replaces: 4/22/2019 (Retires 2336 2/12/18)	Responsible for Updating: Adult/Child/SUD/QI Directors
Approval:  Behavioral Health Director	<u>3-15-2021</u> Date

BACKGROUND:

In May 2016, the Center for Medicare and Medicaid Services (CMS) published the Medicaid and Children’s Health Insurance Program Managed Care Final Rule (Managed Care Rule), which revised Title 42 of the Code of Federal Regulations (CFR), particularly Part 438.68 Network adequacy standards, Part 438.206 Availability of services and Part 438.207 Assurances of adequate capacity and services. The California Department of Health Care Services (DHCS) established Network Adequacy (NA) standards for outpatient mental health services and SUD services inclusive of both adults and children/youth in July 2017. On October 13, 2017, these standards went into law (AB205) and revised W&I code 14197 and CCR Title 28, Section 1300.67.2.2.; and DHCS distributed Information Notice 18-011 in February 2018 informing MHP and DMC-ODS counties of set forth federal network adequacy (NA) requirements; and the following Information Notices 19-020, 20-012, 20-062E and 21-008 in subsequent years that set forth required data submission requirements for County demonstration of NA standard compliance.

Santa Cruz County Behavioral Health Services (BHS) referred herein as “Plan”, which comprises of both the Mental Health Plan (MHP) and the Drug Medi-Cal Organized Delivery System (DMC-ODS) pilot for SUD treatment services, is committed to offering timely and appropriate services to beneficiaries, or a legal guardian acting on behalf of the beneficiary, within both the MHP and DMC-ODS provider networks.

SCOPE:

This policy is the responsibility of all MHP and DMC-ODS In-Network and Out-of-Network Medi-Cal service entities, including County and Contractor direct service program providers.

PURPOSE:

To ensure all network providers adhere to network adequacy and timely access standards consistent with state and federal requirements.

POLICY:

Beneficiaries of Santa Cruz County Behavioral Health Services (“Plan”), inclusive of Mental Health Plan and/or DMC-ODS pilot, will have access to providers and services within timeframes and distance set forth in state and federal regulations.

DEFINITIONS

1. **“24/7 Access Line”** refers to a statewide, toll-free telephone number available 24 hours per day, 7 days per week, 365 days per year, with language capacity to meet the need of Santa Cruz County Medi-Cal beneficiaries. The Plan utilizes 711 and hsabhserviceinfo@co.santa-cruz.ca.us for beneficiaries living with hearing and/or voice challenges.
2. **“Time and Distance”** refers to the number of minutes and miles from the beneficiary’s residence to the closest outpatient adult and pediatric behavioral health (mental health and SUD treatment) providers. Santa Cruz County is identified as a Medium size county; therefore, our NA standard for both MHP and DMC-ODS is within 60 minute or 30 miles.
3. **“Timely Access”** refers to the “appointment waiting time”, or amount of time from the initial request for behavioral health care services, by a beneficiary, or a legal guardian acting on behalf of the beneficiary or beneficiary’s treating provider, to the earliest date offered by the Plan for the appointment for MHP and/or DMC-ODS covered services.
4. **Business Hours:** Monday through Friday, 8:00AM – 5:00PM.
5. **Non-Business Hours:** Monday through Friday: 5:00PM - 8:00AM; Weekends and Holidays 24 hours/day.
6. **DMC-ODS Network:** DMC-ODS is the Drug Medi-Cal Organized Delivery System for Substance Use Disorder (SUD) services. The DMC-ODS Network comprises of County and Subcontractor operated SUD treatment providers with unique service locations and scope of available services.
7. **MHP Network:** MHP is the Mental Health Plan for Outpatient Specialty Mental Health Services. The MHP Network comprises of County and Subcontractor operated SMHS providers with unique service locations and scope of available services.

PROCEDURES

1. **Provider Network.** BHS Plan will maintain and monitor a network of behavioral health (mental health and SUD treatment) providers to provide adequate access to all services covered under the Plan for the anticipated number of Medi-Cal beneficiaries and the characteristics of behavioral health needs.
 - a. **Cultural and Linguistic Capacity:** The Plan will ensure the network will provide services in the beneficiary’s primary (preferred) language either directly or through interpretation and have the capacity to provide culturally responsive services for beneficiaries with diverse cultural and ethnic backgrounds, gender, sexual orientation and gender identity. Plan services will be delivered consistent with the BHS CLAS Plan. The Plan and all network providers shall conduct and ensure ongoing Cultural Competency trainings to their rendering service delivery staff.

- b. **Reasonable Accommodations:** The Plan will ensure the network will provide physical access and reasonable accommodations as indicated.
 - c. **Credentialing:** The Plan will ensure that all rendering network service providers are credentialed as required by 42 CFR, Section 438.214 and CCR Title 9, Section 1810.435, including verification of credentials (including NPI and taxonomy), enrollment into the DHCS Provider Application Verification Enrollment (PAVE) system, ongoing sanction monitoring, Evidence-Based treatment training assurance and other requirements.
 - d. **Hours of Operation:** Contract providers are required to have hours of operation for Medi-Cal beneficiaries that are the same as those provided to beneficiaries with other insurance plans. If the provider only serves Medi-Cal beneficiaries, BHS requires that the hours of operation are comparable to the hours the provider makes available for Medi-Cal services that are not covered by BHS or another County's MHP or DMC-ODS program.
 - e. **Location:** The geographic location of providers and their accessibility to beneficiaries is sufficient to meet the need, and takes into account distance, travel time, means of transportation, and physical access for disabled beneficiaries.
 - f. **Compliance:** The Plan will establish and monitor mechanisms to ensure that network providers comply with network requirements and will take corrective action if providers are out of compliance.
 - g. **Second opinion:** The Plan will provide for a second opinion from a County or network provider; or arrange for the beneficiary to obtain a second opinion outside the network, at no cost to the beneficiary.
- 2. Time and Distance.** The Plan will adhere to time and distance standards set forth by California Department of Health Care Services (DHCS). Outpatient Specialty Mental Health Services (SMHS), including psychiatry, and outpatient SUD services will be located:
- a. Within 30 miles of a beneficiary's residence, or
 - b. Within 60 minutes of a beneficiary's residence
- 3. Timely Access.** In accordance with DHCS standards for timely access, the Plan will ensure that medically necessary services are available for MHP and/or DMC-ODS beneficiaries, or a legal guardian acting on behalf of the beneficiary or beneficiary's treating provider, considering the urgency of the need for services. Requests can be verbal (call or in person) and/or written (fax/email/letter). Timeliness standards are as follows:
- a. **Available 24/7 Access with language capability to beneficiaries.**
 - b. **Routine Outpatient SMH and/or SUD Services, excluding psychiatry and OTP/NTP:** The Plan will provide timely access within 10 business days from date of request to first available appointment.
 - c. **Routine Outpatient Mental Health Psychiatry:** For specialty psychiatric services, the Plan will provide timely access within 10 business days but no later than 15 business

days from the date of request to first available appointment.

- d. Routine ancillary services for the diagnosis or treatment of injury, illness, or other health condition: When the Plan received an ancillary service requests for the diagnosis or treatment of injury, illness or other mental health or SUD condition, the Plan will provide timely access within 15 business days from date of request to first available appointment.
 - e. Routine Opioid/Narcotic Treatment Program (OTP/NTP): For OTP/NTP services, the Plan will provide timely access within 3 business days from the date of request to first available appointment.
 - f. Urgent Services: The Plan will provide urgent services *not requiring* authorization for SMH and/or SUD services within 48 hours of the request date and time. The Plan will provide urgent services *requiring* authorization for SMH and/or SUD services within 96 hours of the request date and time.
 - g. Continuing service requests: When an enrolled beneficiary requests continuing services with the assigned provider, the provider shall schedule the appointment in accordance with the timely access standards, urgency need and the beneficiary's individualized treatment plan.
 - h. Rescheduling offered appointment: When it is necessary for a provider or beneficiary to reschedule an initially offered appointment, the appointment shall be promptly rescheduled in a manner that is appropriate for the beneficiary's behavioral health care needs and ensure continuity of care consistent with good professional practice.
 - i. Notice of Adverse Benefit Determination (NOABD): If the Plan's provider network is not able to offer a first available appointment to meet these timeliness standards, the network provider who received the beneficiary's request must provide the beneficiary notice of timeliness delay, including the reason for delay and date of scheduled appointment that is identified as first available.
 - 1. The NOABD letter must be in the beneficiary's primary (preferred) language and be accompanied by the required four (4) supplemental documents: Language Assistance, NOABD Your Rights, Notice of Appeal Rights and Beneficiary Non-Discrimination. See **3223 MHP/DMC-ODS NOABD Policy** for more details.
 - j. "Wait time" Extension Exception: Per CCR Title 28 Section 1300.67.2.2(c)(5)(G), an appointment time "may be extended if the referring or treating [licensed health care] provider, or the health professional providing triage or screening services, as applicable, acting within the scope of her or his practice and consistent with professionally recognized standards of practice, has determined and notes in the beneficiary's records that a longer waiting time will not have a detrimental impact on the health of the beneficiary."
4. **Out-of-Network (OON) Services**. If the Plan's provider network is unable to provide necessary services (the appropriate level of care as determined by an assessment) covered under the DMC-ODS or MHP contract with DHCS to a beneficiary, the Plan will adequately and timely cover these services out of network for the beneficiary, for as long as the Plan is unable to provide them, and the services are medically necessary.

- a. The Plan shall arrange OON agreements and an appointment for the beneficiary with an OON provider that meets the timeliness standards, either in-person or by telehealth.
 - b. The Plan requires that the OON provider participate in coordination of service authorization and payment.
 - c. The Plan will ensure that the cost to the beneficiary for services provided out of network pursuant to an authorization is no greater than it would be if services were rendered within the Plan's network.
 - d. The Plan shall arrange OON agreements to ensure that American Indian beneficiaries have the option to obtain SMH and/or SUD services from an OON American Indian Health Facility if the beneficiary meets the medical necessity and other requirements for such services.
 - e. The Plan shall arrange OON agreements when necessary to ensure federal transition / continuity of care service requirements are met. See **3229 Transition (Continuity) of Care Policy** for more details.
- 5. Alternative Access Standards(AAS).** If the Plan can demonstrate that all reasonable options to obtain providers to meet the applicable standards are exhausted and still cannot meet the time and distance standard and/or demonstrates that the Plan's delivery structure is capable of delivering the appropriate level of care and access, the Plan shall submit a request for alternative access standards per W&I code 14197 to DHCS for review and approval.
- a. The AAS request must include a description of the reasons justifying the AAS and specific impacted areas, such as zip code, type of service or terrain barriers (mountains, transportation limitations, inhabitable area).
 - b. The use of clinically appropriate telecommunication technology may be considered in determining compliance with the applicable standards
 - c. The AAS request shall be approved or denied by DHCS on a zip code and service type basis.
- 6. Community-Based and Mobile Services.** MHP and DMC-ODS services are to be provided in the least restrictive setting, consistent with the goals of recovery and resiliency, and may be provided anywhere in the community. DHCS will consider a substitute standard, other than time and distance, when the provider travels to the beneficiary and/or a community-based setting to deliver services.
- a. For services where the provider travels to the beneficiary to deliver services, the Plan must ensure services are provided in a timely manner in accordance with the timely access standards and consistent with the beneficiary's individualized treatment plan.
 - b. Community-Based Services include a fixed-location community setting (e.g., school, community center) and/or field-based, mobile, and/or community-based services (e.g., mobile units, satellite sites, community centers) to deliver services to beneficiaries in community setting (NOT including a beneficiary's home).

- c. Plan must submit information to DHCS on the availability and provision of community-based or mobile services.
- 7. Telehealth Services.** The Plan will utilize telecommunications, inclusive of video-audio telehealth services and telephonic services, during an emergency that would preclude in-person service delivery to adhere to network adequacy components (time and distance, timely access and provider ratios for outpatient DMC-ODS, SMHS and psychiatry services) in accordance to Section 2290.5 of the Business and Professions Code and W&I 14197(e)(40).
- a. The Plan may utilize telehealth services to meet network adequacy standards and/or as a basis for AAS approvals; and the Plan shall make contracting efforts as needed to meet network in-person service capacity standards.
 - b. The Plan's network providers shall not require a beneficiary to access services via telehealth (or telephonic) in the absence of such emergency if in-person service delivery is available and preferred.
 - c. In order to utilize telehealth to fulfill NA requirements for time and distance standards:
 - 1. The telehealth provider must be available to provide telehealth services to all beneficiaries in the defined service area.
 - 2. The physical location where beneficiaries receive telehealth services must meet the State's time and distance standards or an approved AAS.
 - d. The Plan's telehealth services shall comply with DHCS's Medi-Cal Provider Manual telehealth policy and telehealth provider must meet the following criteria:
 - 1. Licensed to practice medicine in the State of California;
 - 2. Screened and enrolled as providers in the Medi-Cal program; and
 - 3. Able to comply with state and federal requirements for the Medi-Cal program.
See **2109 BH Telehealth Service Policy** for more details.
 - e. When the Plan's provider network is using telehealth to meet either NA standards or AAS, the Plan must submit information to DHCS on their telehealth providers.
- 8. Changes in Network Capacity.** The Plan must demonstrate that it has adequate capacity to serve the covered beneficiaries in accordance with DHCS' network provider-to-beneficiary ratios standards and report any significant changes to DHCS should they occur. Significant changes include termination of a network provider contract, closing of a network service program and/or impactful loss of workforce providers.
- a. DMC-ODS: A DMC-ODS network provider must notify the Plan whenever there is a change in the contractor's operation that would cause a decrease in two or more services, change in geographic service area, decrease in 10% or more in qualified service providers available to beneficiaries or enrollment of a new population.
 - 1. Mandates Provider Types: Per the DMC-ODS Contract, the Plan is required to provide, or arrange for the provision of, all covered DMC-ODS treatment levels of

care, based on ASAM service criteria, including OTP/NTP, MAT services, outpatient, intensive outpatient, residential (3.1, 3.3 and 3.5) and withdrawal management.

- b. **MHP:** A MHP network provider must notify the Plan whenever there is a change in MHP operations that would cause a decrease of 25% or more in service providers available to beneficiaries, changes in benefits, changes in geographic service area, composition of payments to the provider network, or enrollment of a new population.
 - 1. **Mandated Provider Types:** Per the MHP Contract, the Plan is required to provide, or arrange for the provision of, all covered SMHS, including Intensive Care Coordination (ICC) and Intensive Home Based Services (IHBS). The MHP Network must include providers responsible for delivering ICC and IHBS.
- c. The Plan will report to DHCS and include details of the change and specify the plan to maintain adequate services.

9. MHP and DMC-ODS Network Compliance. The Plan's network provider entities are obligated through Medi-Cal certification and County BHS contracting to adhere to the NA standards set forth in this policy. The Plan has established mechanisms to ensure the monitoring and compliance of these timeliness and network provider standards.

- a. **Timeliness:** Each network entity and their unique service programs shall utilize the County electronic health records, Avatar, for documentation of care, and specifically documenting all Access to Care Requests in the Service Request and Disposition Log (SRDL).
 - 1. All entities shall train their relevant staff on the SRDL usage for accuracy, and request additional Technical Assistance as needed from the BHS Quality Improvement (QI) team.
 - i. See **Avatar SRDL Manual** posted on County's Avatar Resource webpage: <http://www.santacruzhealth.org/HSAHome/HSADivisions/BehavioralHealth/AvatarResources.aspx>
 - ii. The Plan and each subcontracted entity shall be responsible for conducting, at least quarterly, service request timeliness monitoring of the Avatar SRDL Timeliness Report, SRDL form auditing and user monitoring.
 - iii. All NOABDs, including the Timely Access notice, shall be delivered to BHS QI for tracking and storage. Encrypted emails with attached copy of NOABD are to be sent to: AskQI@santacruzcounty.us.
- b. **Network provider capacity:** Each network entity and their unique service programs shall adhere to all network provider requirements for rendering Medi-Cal services as listed above. The entity shall notify the Plan immediately of changes to capacity as listed above.
- c. **Corrective Action:** If the Plan determines that a network provider entity or service program is not meeting the NA standards, the Plan shall take corrective action if there is a failure to comply with timely access requirements as evident by

deficiencies found through data analysis and monitoring practices.

1. The network provider will be required to submit a corrective action plan (CAP) to the BHS Director, and QI Director demonstrating steps the provider will take to come into compliance with the standards.
2. The BHS QI team will monitor the provider's corrective actions and require updated information from the provider on a monthly basis until the provider meets the applicable standards.
3. If the provider is not making satisfactory progress towards compliance with applicable standards, the Plan may impose sanctions pursuant to W&I Code Section 14197.7, including monetary sanctions and the temporary withholding of payments.

10. DHCS Network Adequacy Certification. DHCS is required to certify to federal oversight CMS that the MHP and DMC-ODS respectfully meet the NA standards for availability and accessibility of services. The Plan must ensure that each provider network be sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of covered beneficiaries; and that an appropriate range of services is offered that are adequate for the anticipated number of beneficiaries.

Annually, the Plan must submit data and documentation to DHCS for both MHP and DMC-ODS in a format specified by DHCS that ensures compliance with the following requirements:

1. Time and distance standards - geographic access mapping;
2. Network composition and capacity;
3. Timely access;
4. Continuity/transition of care;
5. Mandatory provider types;
6. Language assistance capabilities; and
7. System infrastructure.

PRIOR VERSIONS: 4/22/19, 2/12/2018. Replaces 2336 (2/12/2018)

REFERENCES: Managed Care Final Rule, Federal Reg, Vol 81, No 88; MHP Contract with DHCS; Provider Network Requirements and DMC-ODS contract with DHCS, Exhibit A, Attachment 1, Program Specifications; CCR, Title 28 Section 1300.67.2.2; CCR Title 9, Section 1810.405 and 1810.435; W&I code Sections 14713, 14717.1 and 14197(d)(1); 42, CFR Sections 438.66, 438.68, 438.206, 438.207, and 438.214